Client Demographic Information

Name: _____ Date of Birth: _____
Address: _____ City: _____ State: ____ ZIP CODE: _____
Phone Number: _____ Email: _____
Cell Phone Number: _____ Work status? _____
Occupation_____ Social Security Number: _____
Marital Status: ☐ Single ☐ Married ☐ Widowed

Emergency Contact: _____ Phone Number: _____

How did you hear about FYZICAL? ☐ Doctor ☐ Friend ☐ Internet ☐ Other_____
How would you like to receive reminders about your appointment? ☐ Text ☐ Phone Call ☐ Email ☐ Any

Are you currently under the care of a Home Health or Hospice Agency? Yes / No ☐ Physical Therapy ☐Nursing
If yes, please name agency: _____ Dates of Service: _____

Do you live alone? ☐ Yes ☐ No
Do you live in a: ☐ House ☐ Apartment ☐ Assisted Living Facility ☐ Nursing Home

How do you consider your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
What problem or issue brings you to therapy? _____
Is your coming to therapy related to a work injury? ☐ Yes ☐ No
When did your symptoms start? _____
What activities are you having difficulty performing?_____
Have you had this problem before? ☐ Yes ☐ No
Have you ever received therapy? ☐ Yes ☐ No
Have you received any recent therapy: ☐ Yes ☐ No
What treatments have you had? ☐ Physical Therapy ☐ Massage ☐ Chiropractic ☐ Other _____
Recent surgery? ☐ Yes ☐ No If yes, Procedure: _____ Date: _____
What test(s) have you had? ☐ Xray ☐MRI ☐CT ☐ Bone Scan ☐ Hearing Test ☐ VNG

Have you fallen in the last year? ☐ Yes ☐ No
If yes, were you injured? ☐ Yes ☐ No
Please Describe: _____
_____

What are your goals for physical therapy? _____
_____

Have you had a significant **DECREASE** in your ability to perform any of the following in the last 3 months?
☐ Dressing Self ☐ Feeding Self ☐ Grooming ☐ Walking ☐ Getting in and out of bed or chairs
☐ Going up and down stairs ☐ Changes in balance or coordination ☐ Falls

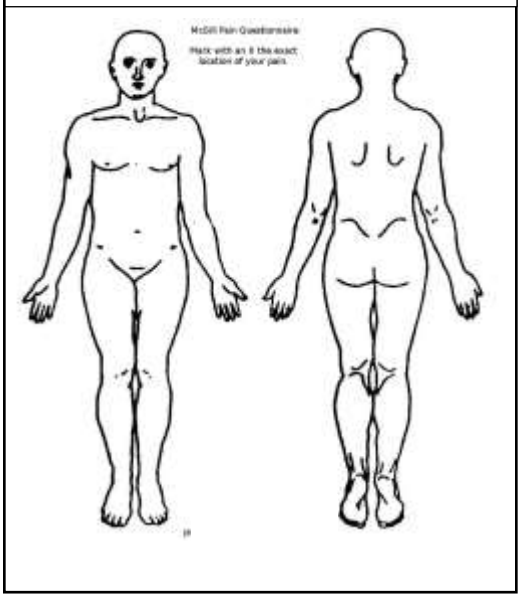
Place marks on lines to indicate your level of pain or symptoms

0= no pain/symptoms 5= symptoms cause you to stop activities 10= must go to hospital

CURRENT	0	1	2	3	4	5	6	7	8	9	10
BEST	0	1	2	3	4	5	6	7	8	9	10
WORST	0	1	2	3	4	5	6	7	8	9	10

Client Demographic Information

Mark or shade the locations of your pain on the picture below



Please describe your pain or chief symptoms: (check all that apply)

- ☐ Light headedness
- ☐ Imbalance
- ☐ Ear pressure/pain
- ☐ Motion intolerance
- ☐ Headaches/migraine
- ☐ Head injury/concussion
- ☐ Tingling
- ☐ Burning
- ☐ Shooting
- ☐ Throbbing
- ☐ Dull pain/ache
- ☐ Sharp pain

Please describe the intensity and pattern of symptoms:

- ☐ Getting better
- ☐ Not changing
- ☐ Getting worse

Symptoms are worse…

- ☐ Morning
- ☐ Afternoon
- ☐ Night
- ☐ Constant

Activities/positions that ***increase*** symptoms_____
Activities/positions that ***decrease*** symptoms_____

Recent night pain or fevers/ sweats	☐ Yes ☐ No	Vision change or double vision	☐ Yes ☐ No
Unintentional weight change	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Depressed mood	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Joint swelling	☐ Yes ☐ No	Nausea, vomiting	☐ Yes ☐ No

Medical History and Family History

CONDITION	PAST	PRESENT	FAMILY	CONDITION	PAST	PRESENT	FAMILY
Rheumatoid Arthritis	☐	☐	☐	Osteoarthritis	☐	☐	☐
Cardiac Problems	☐	☐	☐	Osteoporosis	☐	☐	☐
Stroke/TIA	☐	☐	☐	Peripheral neuropathy	☐	☐	☐
HIV/AIDS	☐	☐	☐	Asthma / Respiratory	☐	☐	☐
Hepatitis	☐	☐	☐	TB	☐	☐	☐
Diabetes	☐	☐	☐	Epilepsy/Seizure	☐	☐	☐
Fibromyalgia	☐	☐	☐	Lower limb edema/swelling	☐	☐	☐

Other Present or Past Medical Conditions: _____
_____

Are you interested in learning how shoe orthotics can help you? ☐ Yes ☐ No

Client Signature _____ **Date** _____
Parent/Guardian Signature (If Minor) _____ Date_____